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AUTHOR Capodanno, Karin H.
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ABSTRACT

The purpose of this paper is to review and critique the literature on the effects of countertransference on the life of the therapist treating patients with borderline personality disorder. Countertransference has long been recognized as an integral component of the therapeutic relationship and may have far reaching effects on both the professional and private life of the therapist. Several factors indicated by the research to be essential in understanding countertransference and its importance in treatment of borderline patients are reviewed. Current views on the psychosocial and neurological etiology of borderline personality disorder are included. Under "Countertransference Issues" the definition of countertransference is explored as it relates to patients with borderline personality disorders, and the broadening of the definition to include countertransference as an intrarelational phenomenon. "Treatment Issues" includes "Psychodynamic Treatment," "Alternative Forms of Treatment," "Dialectical Behavior Therapy," and a discussion of the treatment contract. "The Effects of Countertransference on the Therapist" discusses "Education and Training," "Boundary Violations," "Termination Issues," "Violence Against Therapists," and "Therapist Well-Functioning and Self-Care." The paper concludes with a summary of the findings. (Contains 110 references and 1 figure.) (EMK)

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THE EFFECTS OF COUNTERTRANFERENCE ON THE THERAPIST TREATING BORDERLINE PERSONALITY DISORDER: A REVIEW OF THE LITERATURE

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Karin H. Capodanno

May, 1998

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THE EFFECTS OF COUNTERTRANSFERENCE ON THE THERAPIST TREATING BORDERLINE PERSONALITY DISORDER: A REVIEW OF THE LITERATURE

by

Karin H. Capodanno

APPROVED:

Joan W. Jones, PsyD — Date 5-21-98

Joan W. Jones, PsyD

Cherry G. Steinmeier, Psy.D. — Date 5/21/98

Cherry G. Steinmeier, PsyD

APPROVED:

Patricia L. Pike, PhD, Dean

5/21/98

Date

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ABSTRACT

THE EFFECTS OF COUNTERTRANSFERENCE ON THE THERAPIST TREATING BORDERLINE PERSONALITY DISORDER: A REVEIW OF THE LITERATURE

by

Karin H. Capodanno

Whose feelings are these? The purpose of this paper is to review and critique the literature on the effects of countertransference on the life of the therapist treating patients with borderline personality disorder. Countertransference has long been recognized as an integral component of the therapeutic relationship and may have far reaching effects on both the professional and private life of the therapist. This review will focus on several factors indicated by the research to be essential in understanding countertransference and its importance in treatment of borderline patients. Also included in this review, are the current views on the etiology of borderline personality disorder and historical as well as current trends in treatment.

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EFFECTS OF COUNTERTRANSFERENCE ON THE THERAPIST TREATING BORDERLINE PERSONALITY DISORDER: A REVIEW OF THE LITERATURE

Introduction

The therapist spends many hours in training developing empathy skills. Specifically, the therapist is trained to hear, reflect and interpret the patient's feelings and behaviors in a way that will stimulate growth and positive change in the life of the patient (Rogers, 1980). A major challenge may occur when the patient begins to elicit strong emotional reactions in the therapist (Kernberg, Selzer, Keonigsberg, Carr, & Appelbaum, 1989). The therapist must learn to expect the countertransference and effectively minimize any trauma to the patient that might occur from this phenomenon (Freud, 1963).

The borderline patient in particular, can elicit powerful countertransference feelings in the therapist. Most borderline patients struggle with fear of abandonment, a lack of sense of self, and caldronous rage. Masterson (1983) has stated that borderline patients are experts at searching out and exploiting the therapist's vulnerabilities. The patient seems to be exerting as much effort in destabilizing the therapist as the therapist is in stabilizing the patient. The patient

often attempts to elicit countertransference responses from the therapist in order to shield him/herself from his/her own intrapsychic conflicts. The therapist is challenged to understand the countertransference and use it to aid the patient in better self-understanding. Throughout this process, the therapist must still function professionally and personally. The following questions then arise; How does the therapist take care of him/herself while working with a borderline patient; and in what way does the etiology and treatment affect the life of the therapist?

The purpose of this paper is to review the literature on countertransference with Borderline Personality Disorder (BPD) patients and discuss the implications of the therapeutic relationship on the life of the therapist. The discussion will include a summary of the etiology of BPD, conceptualizing it as a syndrome; the definition of countertransference as viewed throughout the literature; and a critique of the historical and current treatment literature on Borderline Personality Disorder. Finally, the paper will discuss the ramifications on the life of the therapist.

In order to make terminology less confusing, the term "therapist" will denote psychologist, psychiatrist, psychoanalyst or mental health professional; and the term "patient" will be used to describe the individual seeking treatment. The gender of the therapist will remain in masculine form for text discrimination and ease of reading. Borderline personality disorder is diagnosed more often in

females than males (Gunderson, 1984), thus, the feminine pronoun will be used in reference to the patient.

Etiology of Borderline Personality Disorder

Psychosocial Etiology

For a borderline diagnosis to have a credible distinction, it must have boundaries. Theordore Millon states "unless the word is used to signify a class that borders on something, then it has no clinical descriptive meaning at all" (p. 332). Borderline personality disorder is often stated as being a personality disorder that is as diffuse as it is difficult to define. Despite extensive studies on this subject, many researchers fail to agree on a clear definition of BPD. The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association [APA], 1994) describes it as a "pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (p. 650). Borderline personality disorder includes criteria concerned with the current functioning of intense unstable relationships, impulsivity, unstable sense of self, suicidality, affective instability and anger. Tyrer (1994) found few of the DSM – IV [APA] criteria to be typical in the long term functioning of borderline individuals. McGlashan (1986) reports that BPD has a generally good outcome

over time which presents an argument against the condition being a true personality disorder.

Several authors have suggested instead of a criteria based description of BPD, it may be useful to understand the disorder in terms of its various dimensions (Barash, Kroll, Carey, & Sines, 1983; Clarkin, Wideger, Frances, Hurt, & Gilmore, 1983; McLashan, 1983; Perry & Klerman, 1978). Since the delineation of DSM-IV (APA, 1994) criteria, data has accumulated concerning the heterogeneity of BPD. There is a great deal of co-morbidity within the borderline domain and many researchers have adopted a diagnostic approach which relies more on dimensional than traditional categories (Stone, 1994). The DSM-IV (APA, 1994) description of BPD states it is a condition of early adulthood. Several authors have noted that BPD may be described better as a developmental condition and not a personality disorder. These findings in the literature suggest that the concept of BPD may be characterized more as a syndrome than a true personality disorder.

Borderline personality disorder may not be confined to merely one etiology. The biopsychosocial model of mental disorders posits that the interactions of biological, psychosocial and environmental risk factors best account for the development of mental disorders (Engel, 1980). There seems to be a commonality of symptoms in individuals with a borderline diagnosis with many patients describing pathological families. In order to better understand the potential

environmental risk factors, it is necessary to investigate the family of the borderline patient.

Attachment theorists have suggested that the route of continuity from infancy to adulthood is through the individual's internal working model or schema of the relationships between the self and others (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby 1969/1982, 1973, 1980; Bretherton, 1985; Main, Kaplan, & Cassidy, 1988). Several authors have stated that a major factor in the development of BPD is the combination of the parents' over-involvement and under involvement with the child. These behaviors cause the child to become fearful of attachment. Melges and Scwartz (1989) have described the oscillating attachment behavior in borderline patients as fear management. The patient's fears are two-fold; abandonment if she should grow up and become independent from her family, and becoming dominated if she remains close. Empirical studies support Melges and Schwartz's paradigm in findings that state parents of patients diagnosed with borderline pathology experience major conflicts regarding autonomy that prevent them from responding to their adolescent's growing autonomy in appropriate ways (Bezirganian, Cohen, & Brook, 1993; Gunderson, 1996; Kashani, Ezpeleta, Dandoy, Doi, & Reid, 1991; Ludolph, et al., 1990).

Borderline personality disorder appears to be an outgrowth of the family's pathology. It is an adaptive, albeit pathological, choice the patient makes to cope

with a chaotic family system. Benjamin (1993) describes an interpersonal theory of borderline behavior patterns in which family backgrounds of individuals with borderline traits show four major characteristics: (a) the individual with borderline personality disorder is subtly blamed for the chaotic family's problems and is expected to exert control over family misbehavior, (b) chronic episodes of traumatic abandonment are mixed with periods of traumatic over-involvement such as ancestral assault, (c) the borderline patient's attempts at autonomy are perceived as disloyalty to the family, (d) parents of the borderline patient only show concern or love when the patient presents with debilitation, misery or sickness.

The patient and the family are linked together psychodynamically, psychologically and biologically. Linehan (1993) believes that a major cause of BPD is an "invading environment." She defines this as an environment in which the communication of private experiences are met by extreme, erratic or inappropriate parental responses. The behavior of the BPD patient may develop from a reaction toward and from intra-familial interactions. Many authors have suggested that families of borderline patients tend to have a higher incidence of alcoholism, and antisocial personality disorder. Zanarini and Frankenburg (1994) hypothesized BPD develops as a result of serious and chronic maladaptive behaviors by immature and emotionally impaired care-givers. The research of Links and Monroe-Blum (1990) have concluded there are three psychosocial

etiological factors that are supported by the current literature: (a) neglect or deprivation because of early loss or separation from a primary caregiver, (b) the consequence of physical or sexual abuse in childhood, and (c) the developmental consequences of having both parents impaired and unable to carry out their parental functions.

The relationship between childhood sexual abuse and the diagnosis of BPD appeared to be consistent across six case control studies (Links & Munroe-Blum, 1990). Links and Van Reekum (1993) also demonstrated an etiological link between childhood sexual abuse and the diagnosis of BPD. Their study (N= 55) included, 50 female and 5 male subjects, selected from the McMaster University network of inpatients. The subjects had a mean age of 29 and were selected on the basis of a score of 7 or greater on the Diagnostic Interview for Borderlines (DIB) (Gunderson, Kolb, & Austin, 1981). The DIB consists of 24 items that yield five subscales: social adaptation, impulsivity, affect, psychosis, and interpersonal relations. A score of 7 or greater is used for the cutoff for borderline pathology. The subjects were interviewed with regard to the following childhood antecedents: (a) separations from mother for more than three months, (b) occurrence of foster home placement, (c) physical and sexual abuse by caretakers during childhood, and (d) evidence of intact parental marriage during their childhood. An independent rater also collected in-depth psychiatric histories on the subjects' biological parents in order to assess the degree of parental

impairment. Pearson correlation coefficients were calculated between the antecedents, degree of parental impairment and total score on the DIB. Using a stepwise multiple regression, sexual abuse by caretakers and the degree of parental impairment together explained almost 20 percent of the variance ($\underline{R}^2$ = 0.19). The multiple regression was repeated to determine the increment in $\underline{R}^2$ produced by childhood sexual abuse after all the other antecedents and parental impairment variables were entered. This analysis was limited to female subjects ($\underline{N}$=48). Childhood sexual abuse accounted for an additional 13 percent of the variance in borderline pathology after the other variables had been controlled.

As indicated above, borderline patients with a DIB score of 7 or greater have a significantly higher report of childhood sexual abuse. This finding seems to strengthen the link between childhood sexual abuse and BPD. It suggests that the occurrence of childhood sexual abuse has an independent relationship with the characteristics of BPD and is not a result of a confounding relationship with other possible etiologic factors.

Methodologically, this study was limited by the inability to demonstrate a temporal relationship between childhood sexual abuse and the development of BPD. The authors also did not explore the definition of parental impairment as it relates to information beyond any psychiatric history that was previously recorded. Finally, the data collected on childhood sexual abuse was limited only to primary care givers and did not include perpetrators the child may have encountered

outside of the home environment. This study, however, does contribute significantly to the mounting evidence which suggests that childhood sexual abuse may be an independent contributing factor in the development of borderline personality disorder.

Other studies indicate similar results. The research suggests that childhood sexual abuse is a contributing factor to the development of borderline personality disorder (Guzder, 1994, 1988; Ludolf, et al., 1990; Paris, Zweig-Frank, & Salzman, 1993). These studies all suggest that there are precipitating factors in a child's development that may lead to a diagnosis of borderline personality disorder. In particular, these factors may be taking place in the home or with the child's primary caretakers. Research also seems to suggest borderline pathology may be more prevalent in female children. Female children experience a higher rate of childhood sexual abuse than male children (Brown & Anderson, 1991). All of these factors point toward the formation of BPD in an individual, but it still remains unclear as to how the development continues through adulthood.

The research clearly shows that early intervention would be extremely beneficial to borderline producing families. The difficulty lies in the fact that personality disorders are rarely diagnosed in children, and the DSM-IV (APA, 1994) criteria may not be suitable for this age group. A recent Canadian study by Guzder, Paris, Zelkowitz and Marchessault (1996) examined risk factors for borderline pathology in latency aged children. They assessed 98 subjects who

were consecutively referred for admission in a children's day treatment program. The children were divided into two groups of borderline and non-borderline subjects with 41 and 57 subjects in each group respectively. There were no significant differences between age and gender in either of the groups. Both groups were diagnosed according to Diagnostic and Statistical Manual of Mental Disorders, third edition Revised (DSM-III-R; American Psychiatric Association [APA], 1987) criteria for BPD and the Child version of the Retrospective Diagnostic Interview for Borderlines (C-DIB-R), an instrument designed to identify borderline children through chart review (Gunderson & Kolb, 1978). The C-DIB-R requires a score of 7 or greater as the cutoff for borderline pathology. The functional status of each child was scored by the same clinician based on the Children's Global Assessment Scale (CGAS) (Shaffer, Gould, & Brasi, 1983).

There were significant Pearson product moment correlations between C-DIB-R scores and cumulative abuse scores ($r = .36$, $p < .001$), and between C-DIB-R scores and cumulative parental dysfunction scores ($r = .23$, $p < .05$). There was also a significant correlation between C-DIB-R scores and age ($r = .27$, $p < .01$) and gender ($p < .002$) with females having higher scores. A regression analysis demonstrated that cumulative abuse, gender, and age were all significant independent predictors of borderline pathology ($p < .0001$).

This study indicates that psychological risk factors for borderline pathology in children are similar to adult borderline pathology. Rutter (1987, 1989) has stated

that single negative experiences during childhood are weak predictors of psychopathology whereas, multiple negative experiences are strong predictors. It should be noted that childhood sexual abuse seldom occurs in isolation, but rather in the context of other risk factors, such as physical abuse, verbal abuse, and neglect (Guzder, et al., 1996). These results did find some support for the C-DIB-R in that the research was able to show this measure could identify the difference between borderline and non-borderline children on variables that were similar to those which differentiate between borderline and non-borderline adults. The researchers however, could not predict a continuity of borderline pathology between childhood and adulthood.

The methodology of the Guzder et al. (1996) study utilized retrospective data through chart review. The authors were therefore unable to collect data on other specific risk factors including organicity. Through further research, the C-DIB-R and the development of other specific risk factor questionnaires, may become useful instruments in the prediction of borderline personality disorder. Until instruments are developed to detect early intervention, the child in a pathological family has very few choices.

The continually impaired interactions between the child and parent may lead to life-long self-destructive behaviors. Major conflicts regarding autonomy and the child's desire for safety may predispose a child to borderline traits (Bezerganian, Cohen, & Brook, 1993; Gunderson, 1996; Kashani, et al., 1991; Ludolph, et al.

1990; Melges & Schwartz, 1989). In agreement with the previous studies, Allen and Farmer (1996) proposed a model that bridges the gap between childhood borderline traits and the development of diagnosable borderline personality disorder. This model was derived from clinical data collected within a private practice environment. The word "child" in the following Allen and Farmer (1996) model refers to the borderline patient.

The child realizes that she is the center of her parents' attention and concludes that her parents have some needs that must be fulfilled. She then comes to the conclusion that the needs of the parents are contradictory in that they must remain angry and focused on her continuously. The child then realizes the parents need an object of hatred to act as a scapegoat for their own problems. These needs are perceived as demands to become both a dependent and hated object. If the child could fulfill both of these roles, the parents would be provided with a constantly available object on whom to displace their anger. Moreover, if the child retaliates in a hateful manner, the parents are given justification for their oscillation toward uninvolvement and neglect of the child. Ultimately, the child's only way to a precariously safe existence is to begin anticipating the needs of her parents and enacting a role reversal by becoming her parents' parent. Allen and Farmer's (1996) model implies the behaviors of childhood are persistent into adulthood.

The clinical data seems to support the hypothesis of a dimensional view of the diagnosis of borderline personality disorder (Allan & Farmer 1996; Bezerganian,

et al., 1993; Gunderson, 1996; Kashani, et al., 1991; Ludolph, et al. 1990; Melges & Scwartz, 1989). Developmental aspects of the child in relation to her care-givers and early home environment may be a determining factor in the later development of BPD.

As stated earlier, borderline personality disorder is broader than a simple set of criteria. There are many factors working together to form the syndrome of borderline personality disorder. In this section I have discussed the psychosocial and environmental components. The possibility also exists of other contributing factors that enable borderline pathology to endure into adulthood. In the next section, the neurological etiology of borderline personality disorder will be discussed.

Neurological Etiology

Clinical data has shown that individuals diagnosed with BPD exhibit cognitive and perceptual problems. The research describes borderline pathology to include difficulty drawing logical inferences about relationships between people and events, dichotomous thinking, quasi-psychotic thinking, and interpretive deficits (Judd & Ruff, 1993). The prevalence of quasi-psychotic and disturbed thinking is so great that they are thought to be markers of BPD (Zanarini, Gunderson, & Frankenburg, 1990). Studies using Rorschach protocols have demonstrated borderline pathology patients have deviant communication patterns and difficulty maintaining or shifting cognitive sets. Borderline patients also seem to have

difficulty detecting their errors in reasoning (Berg, 1983). Exner (1986) describes the BPD cognitive style as "immature and/or inadequate organizational structure" (p.469).

Several authors have originated studies addressing cognitive deficiencies in the general intelligence and cognitive functioning of BPD patients. Results of the Wechsler Adult Intelligence Scales (WAIS) show borderline patients to have greater intra and inter-test scatter, odd word usage, disruptions of boundaries between concepts, and lapses in logical thinking on tasks requiring extensive use of language (Berg, 1983; Carr, Goldstein, Hunt & Kernberg 1979; Widiger, 1982). The research suggests that borderline patients suffer from uneven cognitive development, functioning and efficiency (Berg 1983).

Judd and Ruff (1993) designed a study to research cognitive functioning in borderline patients from the perspective of an underlying brain dysfunction. Their study was based on Alexander Luria's theory of higher cortical functioning (Luria, 1973; 1980) which posits that the functions of the brain develop during the "period of communication between the child and adult when function was shared between two people" (Vygotsky, cited in Luria, 1973, p.247). This theory suggests a very early onset of underlying brain dysfunction in borderline patients. Luria has proposed that the area of the brain responsible for information processing tasks such as encoding and storage, which are central to learning and memory, may be dysfunctional. This dysfunctional area may cause faulty and distorted learning,

and poor integration and synthesis of concepts (Judd & Ruff, 1993). The inability to process concepts may be the underlying reason borderline patients have such unstable interpersonal relationships.

The Judd and Ruff (1996) study was comprised of a sample (N = 50) including 25 non-borderline archival patients from an affiliated hospital and 25 BPD patients recruited from an outpatient psychiatric clinic. Because archival data was used; the researchers were able to match the groups exactly on gender and age. The BPD patients were medication free, met DSM-III-R (APA, 1987) criteria for borderline personality disorder, and had (DIB) scores of 7 or greater (Gunderson, et al., 1981). Both the borderline and control group were given the San Diego Neuropsychological Battery (SDNB) (Ruff, 1985). The SDNB has been normed on a sample of 360 adults and has been used clinically for the past 12 years. The control group were normal volunteers who took the San Diego Neuropsychological Battery (SDNB) for research purposes. The mean Wechsler Adult Intelligence Scale-Revised (WAIS-R) full scale, verbal and performance IQs were within the average range for both groups. Results were analyzed using a within subjects multivariate analysis of variance, (MANOVA) which indicated that the differences in Luria's two components of memory ($p < .003$) and complex intellectual processes ($p < .001$) were significant. The performance of the borderline patients was significantly lower on recall portions of the battery with their results having either distorted or missing parts.

These findings seem to support the hypothesis that cognitive dysfunction is present in BPD patients. This support gives more credence to viewing borderline personality disorder as a syndrome rather than a criteria based disorder. The data suggest that borderline patients have a dysfunction in encoding or learning new complex information, which Luria (1973) describes "as the conversion of concrete perceptions into functional patterns, and the integration and transformation of complex information into symbolic schemes in a rapid and fluent manner" (Judd & Ruff, 1993, p. 280). Methodologically, this study was limited by the lack of a control group, and instruments used to detect learning disabilities. Structured interviews were not included to gather systematic analysis of DSM-III-R (APA, 1987) Axis I or Axis II co-morbidity.

The chaotic family life of the borderline patient seems to work in tandem with her neuropsychological dysfunction. A cognitively vulnerable child and an abusive family environment are two powerful components working together to establish traits within a child which may later lead to diagnosable adult BPD. From another perspective, it can be stated that early and chronic childhood trauma may actually interfere with neurocognitive development. It is yet unclear which precedes the other, but it is clear that poorly integrated cognitive-affective schemas of self in relation to others, may be a contributory factor to the unstable relationships characterized by BPD.

Viewing BPD as a syndrome includes looking not only at early childhood risk factors (Guzder, et al. 1996), but also considering the neuropsychological components of the individual (Judd & Ruff, 1993). The use of neuropsychological testing enables the therapist to uncover the cognitive difficulties of the patient. Future research may discover possible links between learning disabilities and BPD. Treatment can then address both the emotional and cognitive needs of the patient. This study examined evidence of neuropsychological deficits in borderline patients. Several authors have suggested that there is a circular connection between a borderline patient's home environment and neuropsychological deficits. The following studies assert that brain dysfunction causes borderline personality disorder.

Using instruments sensitive to information processing, the research of Burgess (1990) found more frontal lobe impairments among subjects with BPD than among controls. Burgess'(1991) second study, found further evidence to suggest that self-injurious behavior of borderline patients is highly correlated with attentional testing, (r =.555, p =.03) and memory testing (r =.693, p =.04). Many of the subtests used to derive these scores are considered to reflect frontal lobe processing. Van Reekum (1993) also looked at evidence for BPD from a neuropsychological viewpoint. Borderline patients are impulsive, often self-mutilative, affectively disinhibited, and frequently fail to apply gains made in psychotherapy. Despite apparent learning, these traits suggest they suffer from a

dysfunction in limbic and frontal sites (van Reekum, 1993). Van Reekum, Conway, Gansler, (1993) conducted a study to determine evidence of frontal lobe dysfunction in BPD patients. The neuropsychological instruments used to demonstrate these deficiencies were: The Wisconsin Card Sorting Test, Rey-Osterrieth Complex Figure Drawing Test (copy and recall) and Trails B battery. Seven of the nine patients whose test results were interpretable had evidence of frontal system dysfunction. The deficits most often displayed included impulsiveness, cognitive inflexibility, poor self-monitoring and perseveration. Based on these findings, the authors concluded that borderline personality disorder patients have evidence of frontal lobe dysfunction.

Researchers have described BPD from a dimensional perspective throughout the psychosocial and neurobiological literature on the etiology of borderline personality disorder. Tyrer (1994) describes the diagnosis of borderline personality disorder as a "go-between" which ties together personality disorders, disorders of development, substance abuse, mood and adjustment disorders, making them a single group (see figure 1, p. 19). The various criteria can also be understood through neuropsychological deficits as well. Borderline personality disorder is more than a categorical diagnosis.

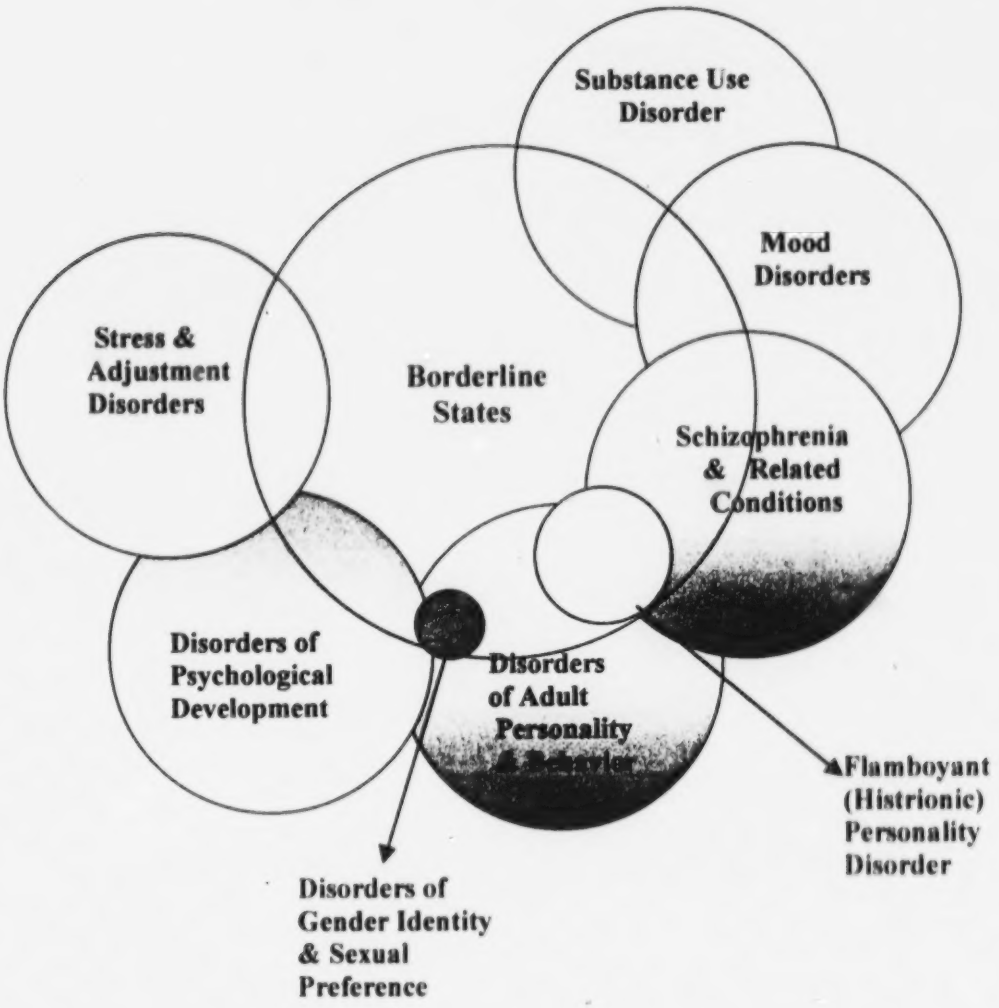

Figure 1. Venn diagram indicating the borders of borderline states (Tyrer, 1994)

The current research seems to indicate that brain dysfunction may be evident in borderline personality disorder. Brain dsyfunction affects an individual's behavior and increases behavioral disturbances that interact with environmental and psychodynamic factors to produce behavioral changes. Future research in this area should incorporate studies of brain dsyfunction, environmental and psychodynamic factors in order to determine in which in direction the interactions occur. Several authors have noted that borderline personality disorder is a syndrome of behaviors (Burgess, 1990, 1991; Judd & Ruff 1993; van Reekum, Conway, & Gansler, 1993). As research in this area continues, treatment for borderline personality disorder patients will encompass broader areas including rehabilitation of cognitive deficits, which may increase coping skills.

Countertransference Issues

As previously discussed, borderline personality disorder has dimensional qualities better understood as a developmental syndrome than a criteria-based personality disorder. Broadening the therapist's perspective on the etiology of BPD will allow him to more effectively use the countertransference relationship. If the therapist grasps the underlying etiology of the behaviors he observes, he may be able to structure treatment to more effectively assist the patient.

It is not the purpose of this paper to present an extensive review of the literature on countertransference. However, it is necessary to summarize the main definitions current to the field as they pertain to borderline psychopathology.

Definition of Countertransference

Freud first used the term countertransference in his 1910 paper, "The Future Prospects of Psychoanalytic Therapy." He stated,

> We have become aware of the 'Countertransference' which arises in him (the analyst) as a result of the patients' influence on his unconscious feelings, and we are most inclined to insist that he shall recognize this countertransference in himself and overcome this. We have recognized that no psychoanalyst goes further than his own complexes and internal resistances permit; and we consequently require that he begin his activity with a self-analysis and continually carry it deeper while making his observations on his patients. (Freud, 1957, pp. 139-151)

Freud viewed countertransference as a negative and potential liability in the consciousness of the analyst. While countertransference does speak to the conflicts of the therapist, it has been brought about by the relationship of that particular therapist and that particular patient. Therefore, it may also be viewed as a useful tool in the work with borderline patients. As psychotherapy evolves, countertransference is also being viewed from a more positive perspective. The

following authors give their views on countertransference and its uses and misuses in the therapeutic relationship with borderline patients.

Heinmann (1950) regards countertransference as a plausible benefit in understanding the patient. She states that it is essential that the therapist "sustain the feelings which are stirred in him as opposed to discharging them in order to subordinate them to the analytic task" (p. 81). Heinmann's statement proposes a positive use for countertransference and presents it as another method to understand the patient. Kernberg (1965), who has worked extensively with borderline patients, defines countertransference from a "totalistic" point of view. He defines totalistic to mean "the total emotional reaction of the psychoanalyst to the patient in the treatment situation" (p. 21-22). Masterson (1990) views countertransference as a prominent issue with borderline patients because the phenomenon "combines the intensity of the patient's transference acted-out projections, and the human vulnerability of a therapist" (p. 190).

Use of Countertransference

The trend in the literature seems to be heading in the direction of conceptualizing countertransference not as an isolated reaction to a patient's behavior, but an intra-relational experience that informs the therapist in an intimate way about the experiences of the patient. Countertransference may be a reaction to the patient's age, gender, or appearance. A patient's mood may in turn cause a change in the therapist's mood. A patient who presents as detached may cause the

therapist to feel bored or sleepy; an anxious patient may cause the therapist to become anxious (Horner, 1991). Hedges (1983) views countertransference as a "replication of idiosyncrasies of the symbiotic or past symbiotic relationships within the context of the therapeutic relationship" (p. 198). The patient vigorously attempts to engage the therapist into joining her in her world. The therapist not only observes the patient's world through words and behaviors, but begins to experience it as well. The patient attempts to achieve a merger with the therapist through the countertransference. The stronger the unresolved conflict is within the therapist, the more difficulty he will have working the particular issue through with the patient. Often the area of sexuality becomes most difficult and dangerous for the unaware therapist. Sexual acting out is a taboo in the therapeutic relationship. However, the existence of sexuality is constant and frequently denied. The therapist must be continuously aware of his own erotic response toward the client and allow himself the awareness of his client's sexual feelings and behavior toward himself. Kroll (1988) has stated, "the therapy situation is the arena in which the therapist works out his own issues during the process of working with the patient." (p. 186-187). In the same way that a therapist protects himself against vulnerable issues of criticism, engulfment, seduction, or passivity, he may also attempt to coerce or collude with the patient to meet his own needs.

Current trends view countertransference as a potentially positive addition to treatment because it allows the therapist to experience the intense, primitive and

regressive defenses of the patient (Rosenbush, 1989). The caveat remains that countertransference is a double-edged sword and a therapist committed to personal growth will be in a better position to understand his own countertransference and use it successfully to assist the patient.

Researchers in Great Britain have recently developed and presented an instrument that has had some success in the detection of countertransference issues in treatment of borderline patients. The Self-State Sequential Diagram (SSSD) (Ryle, 1996) is a questionnaire that tracks the oscillating self-states of the borderline patient as well as charting countertransference issues of the therapist. The questionnaire is used simultaneously by the borderline patient as a self-monitoring device and a countertransference-tracking device for the therapist. The therapeutic modality used in the study was Cognitive-Analytic therapy with a duration of 16-24 sessions. Both the patient and therapist fill out a questionnaire at the conclusion of each session and these are compared on a grid. The data supported the researcher's hypothesis that SSSD can track and predict self state shifts in the patient and minimize countertransference by reducing the therapist's unhelpful response patterns (Ryle, 1996). The findings of this study are preliminary in that the range of questions were narrow and only a small sample was used ($\underline{N} = 2$). However, the successful development of such a questionnaire could have great implications for treatment of borderline personality disorder.

Countertransference has evolved from a neurotic conflict within the analyst to a measurable concept beneficial for the patient. The intra-relational phenomenon of countertransference can occur only in the presence of both the patient and the therapist. As stated previously, countertransference has many implications for the life of the therapist. As the discussion on the borderline patient's effect on the therapist continues, these ramifications will be discussed in detail.

Treatment Issues

Countertransference may be viewed as a function of psychoanalytic tradition, but experiencing therapy with a borderline patient, regardless of modality, presents challenges to the therapist. Even in laboratory settings, working with borderline subjects can prove to be challenging to the most skilled researcher. In the following section, historical treatment modalities will be explored along with current trends in treatment. The use of the treatment contract along with suicidal and parasuicidal behaviors of borderline patients will also be discussed in this section.

Psychodynamic Treatment

Historically, borderline personality disorder has been treated in the psychoanalytic tradition with long term and intense psychotherapy. Kernberg (1972) claims intensive therapy is more beneficial than supportive therapy. There are some borderline patients that will benefit from this type of treatment but the

current research is unable to distinguish this subgroup from other borderline patients. As previously stated, a primary symptom of BPD is impulse control. Keeping an individual with a lack of impulse control in intensive treatment is often difficult. The dropout rates for borderline patients in twice-weekly psychodynamic psychotherapy sessions are as high as 46 to 67 percent after six months (Gunderson, 1984; Gunderson, et al., 1989; Skodol, Buckley & Charles, 1983; Smith Keonigsberg, Yeomans, Clarkin, & Selzer, 1995). Again from the perspective of a borderline syndrome, responsiveness to various treatments may be associated with the differences in the criteria used to diagnose the individual (Angus & Gillies, 1994).

Studies have been conducted on the profiles of borderline patients who drop out of treatment. The majority of dropouts have strong narcissistic traits and rigidly adhere to tendencies of self absorption and self reliance (Homer, & Diamond, 1996). The borderline patient yearns for both complete attunement and complete autonomy, while her impulsive nature drives her to oscillate between these two poles. The strength of the psychodynamic relationship continues to be the holding environment, and ironically, that same bond drives the borderline patient away from treatment. It is often the impulse for complete autonomy that causes the borderline patient to drop out of therapy.

Alternative Forms of Treatment

There is no specific data on the 46 to 67 percent of patients who drop out of treatment as they seem to disappear in follow-up studies. Borderline patients live from crisis to crisis and can be suicidal one day and fiercely autonomous the next. The 46 to 67 percent of patients who drop out of therapy may have found their own alternative form of treatment in an emergency room visit or an overnight "hold". Crisis intervention may be the most beneficial form of treatment for this subgroup of borderline patients because of their chronic instability (Paris, 1993). Visits to an emergency room or therapist's office may be enough to contain their dysphoria and impulsive behaviors. The difficulty lies in choosing which borderline patients will benefit from long term intensive treatment and who will flee. At this point, clinical acumen seems to play a greater role in the therapist's decision making process than factual data.

In an attempt to treat the many forms of the borderline syndrome, various pharmacological interventions have been employed. The goals of pharmacotherapy are to define the differences between state symptoms and trait vulnerabilities, and to then utilize medication as a means of identifying clinical subtypes in order to find a biological basis for classification (Soloff, 1994). Reductionist thinking would posit the notion of a pharmacological cure based on the hypothesis of single neurotransmitter dominance within symptom domains. As hopeful as this may sound, the various symptoms within the borderline syndrome

prove it to be too simplistic. Borderline personality disorder is a psychobiological syndrome and there is no drug treatment for certain learned dynamics. Different aspects of the syndrome manifest themselves at different times within the patient. Pharmacological control of affective disregulation, impulsive aggression, cognitive distortion and anxiety are helpful in ameliorating symptoms which can be disruptive to treatment as well as to quality of life (Soloff, 1994). In working with borderline patients, it may be the therapist's fantasy in collusion with the patient, to attempt to "cure" the patient with a "magic pill".

Dialectal Behavior Therapy

Through her extensive research with suicidal and parasuicidal borderline patients, Linehan (1993) has developed Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy is a cognitive-behavioral psychotherapy based on a biosocial theory that views the borderline condition as a result of the transactional relationship between a child, who is predisposed constitutionally to emotional distress, and the continuous invalidation by the early care-givers of the child's attempt to cope with negative emotion. This continuous invalidation by the care-givers causes the child to fail in learning adaptive ways to regulate emotions or handle personal problems. This chronic emotional dysregulation leads to self-destructive methods of coping with emotional pain. Individuals with BPD have a faulty emotional regulatory system and employ suicidal and parasuicidal behaviors to cope with negative emotions. For an in-depth study of DBT, the reader is

referred by Linehan, Marsha (1993). Cognitive Behavior Therapy for Borderline Personality Disorder. The Linehan model of treatment consists of group and individual therapy. The focus of group therapy is psychosocial skills training where patients can learn to relate to others as well as to minimize feelings of isolation. Individual therapy applies directive problem solving techniques, as well as supportive techniques such as reflection, empathy and acceptance, in addition to techniques from eastern philosophies, particularly Zen Buddhism.

Dialectical Behavior Therapy targets the reduction of suicidal behavior and other behaviors which interfere with therapy and with quality of life, and replaces these dysfunctional behaviors with new skills learned through the skills training component of treatment (Shearer & Linehan, 1994). An outcome study to measure the effectiveness of DBT was conducted after the subjects had completed a one year course of treatment (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The study included of 44 subjects divided evenly into two groups. The groups were randomized between individual peer group DBT treatment and treatment as usual (TAU) in the community. In order to participate in the study, the volunteers had to meet the following criteria: (a) DSM-III-R (APA, 1987) criteria for BPD; (b) a score of 7 or greater on the Diagnostic Interview of Borderline patients (Gunderson, et al., 1981); (c) at least two incidents of parasuicide in the past five years with one during the past eight weeks; (d) absence of the following Axis I conditions as described by DSM-III-R (APA, 1987) criteria schizophrenia, bipolar

disorder, current substance dependence, or mental retardation; (e) age range of 18-45; and (f) an agreement to study conditions including termination of other individual psychotherapy if assigned to the DBT condition.

Subjects were assessed at pretreatment, four, eight and twelve months post-treatment. An assessment on each subject was made on the number of parasuicidal acts and episodes, medical risk of parasuicide and types, as well as amounts of professional mental health and medical treatment including inpatient psychiatric care. The subjects were also assessed for mood and adjustment via questionnaire and observer rating measures. A naturalistic post-treatment follow-up was conducted and the subjects were contacted at six and twelve months after completion of treatment (Linehan, Heard, & Armstrong, 1993).

The results of a Mann-Whitney one-tailed U test revealed DBT subjects participated in fewer parasuicidal acts than TAU subjects through the course of treatment ($z = 2.69$, $p < 0.01$). The findings also revealed that the medical risk of parasuicide was lower for DBT subjects ($p < 0.05$). Based on these findings, Linehan et al. suggest that DBT was more effective at decreasing parasuicidal behavior in comparison to TAU. Dialectal Behavior Therapy was also more effective in reducing both the number of parasuicidal acts as well as the medical risk for the parasuicides that did occur. The post-treatment at six and twelve months revealed that the DBT subjects remained superior to the TAU at the six month assessment on both number of parasuicides and parasuicides requiring

medical treatment. However, the twelve-month post-treatment assessment revealed that both groups were no longer different in their results. A one-year course of DBT treatment appears to be more helpful in the borderline population than TAU, but does not result in sustained gains over time.

Statistical analysis revealed that DBT was also more successful in attracting and retaining subjects than the TAU control group. After referral, 100 percent of the DBT subjects began treatment compared to 73 percent for controls ($z = 2.75$, $p < 0.003$). Eighty-three percent of the DBT patients remained in treatment compared to only 42 percent of the controls ($z = 3.59$, $p < .001$). Dialectical Behavior Therapy attracted subjects as well as retained subjects longer than TAU in the community. One potential confound of this study was cost of treatment. Dialectical Behavior Therapy was offered at no cost while TAU involved cost. However, there was no difference in cost between TAU subjects.

Subjects receiving DBT had fewer days of inpatient psychiatric hospitalization than the TAU group over the year of treatment ($z = 1.74$, $p < 0.05$). Dialectical Behavior Therapy appears to be a consistent factor in shorter hospitalization both during and after one year of treatment.

Finally, results of questionnaires measuring depression, hopelessness, reasons for living and suicidal ideation, did not find any significant differences between groups. Approximately one-half of the subjects received a larger number of questionnaires and were also rated by interviewers blind to the treatment

conditions. The group of DBT subjects receiving the larger number of questionnaires had significantly better scores on measures of general adjustment (GAF), global social adjustment, interpersonal relations with friends, employment, overall work performance, financial adjustment, house hold duties, anger, anxious rumination, emotional regulation and interpersonal problem solving as compared to TAU subjects after twelve months of treatment. The questionnaire seems to indicate that DBT was also effective in controlling behaviors that interfere with the patient's quality of life. However, even with improvement on these measures, the DBT subjects were still in the impaired range when compared to normal samples. Even though DBT did not appear to affect depression and hopelessness, it did seem to improve functional quality of life in a number of areas. The DBT subjects appeared to be more capable of tolerating distressing situations and more able to function while emotionally distressed. Thus this study demonstrated the effectiveness of DBT for its main targets of parasuicidal behaviors and therapy interfering behaviors. (Shearin & Linehan, 1994).

The Treatment Contract and Countertransference

The aforementioned treatments are distinct but share one commonality: the contract between the patient and the therapist. Research seems to indicate that inclusion of a therapeutic contract within the treatment plan may ensure a higher compliance rate for treatment. Kernberg believes establishing an initial treatment contract with a patient "lays out the conditions and expectations of the treatment

and is the foundation of the therapeutic alliance" (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989, p.39).

Yeomans, Selzer & Clarkin (1992, 1993) note the relationship between poorly contained hostility and psychotherapy drop-out rates is significant and establishment of a treatment contract may reduce drop-out rates in borderline patients. The therapeutic contract provides a safe environment for the unfolding of therapeutic work. Its primary focus is not to extinguish acting out behaviors but to provide a proscribed environment for the patient-therapist relationship. Further research by Yeomans et al., (1994) demonstrated that the therapist's contribution to both the development of the contract and the therapeutic alliance correlated positively with the length of time a borderline patient remained in treatment. The contract compels the healthy aspects of the borderline patient's ego to join with the treatment (Bloom & Rosenbluth, 1989).

Looking at BPD from a dimensional perspective, the concept of a treatment plan could be expanded to include the treatment contract as an integrated component of the therapeutic alliance. A treatment plan conceptualized dimensionally, presents the borderline patient with an opportunity to exercise internal control over impulses and affect, and also acts as a stabilizer for the therapist by containing any negative countertransference. If medication is deemed necessary as supplemental treatment, the collaborative therapeutic relationship is essential in evaluating the medication's effect on symptomology. In all aspects of

treatment, a contract agreed upon by the patient and the therapist is vital for a successful therapeutic experience.

The therapeutic contract is also vital for suicidal or parasuicidal borderline patients. Suicide and parasuicide are major concerns when treating the borderline patient. As stated earlier, dysphoric mood and lack of impulse control are two components of the borderline syndrome that may lead to suicidal behavior. While research has found that some borderline patients actually become less symptomatic with age, (Paris, 1993), other studies have shown that nearly ten percent of borderline patients are likely to commit suicide (McGlashan, 1986). Conclusive predictors of suicide have not yet been discovered because there are few studies related to completed suicides. Individual studies however, have discovered significant predictors of suicide. Stone (1990) found that borderline patients who are also substance abusers, have a higher rate of suicidality. Paris, Nowlis, and Brown (1989) found that the only item on the Diagnostic Interview for Borderlines that predicted a later suicide attempt was a previous suicide attempt. These researchers also discovered a link between higher levels of education and suicide in borderline patients. More studies are needed to accurately define predictors of suicidality as well as the long-term outcome of patients with borderline personality disorder.

It is a logical conclusion if borderline personality disorder is viewed as a syndrome, then treatment must come from more than one modality. It appears

through the work of Paris (1988, 1993) and Shearin and Linehan (1994), that there is a progressive and eclectic method of treatment as the syndrome fluctuates and changes. The literature indicates as patients with borderline pathology reach middle age, the majority no longer exhibit acute symptoms or meet diagnostic criteria for borderline personality disorder (Plakun, Burkardt, & Muller, 1986; McGlashan, 1986; Paris, Brown, & Nowles, 1987; Stone, 1990). Vaillant (1997) found that as an individual matures, her impulsivity decreases and is replaced by more mature defenses. The patient may reduce the likelihood of symptom reoccurrence by avoiding certain situations that exacerbate her symptoms. Borderline personality disorder is an impulse spectrum disorder (Zanarini, M., 1993) and this is reflected in the biopsychosocial nature of successful treatment modalities.

The Effects of Countertransference on the Therapist

Education and Training of the Future Therapist

Thus far, the discussion has centered around the borderline patient and successful treatments based on current research. The focus of the remainder of this paper will be the effects of countertransference on the therapist working with borderline patients. In this section, particular emphasis will be given to the education and training of therapists in the area of countertransference,

understanding therapeutic boundaries, violence against therapists and finally, results of studies regarding therapist well-being and self care.

Patients come into treatment with various needs depending on their pathology and may even fantasize that the therapist will satisfy some or all of these needs. It is essential that graduate schools training future psychologists include course work specifically related to the ongoing countertransference and dynamic issues of sex and rage in the borderline patient. The therapist may often teeter between Gutheil and Gabbard's (1993) libidinal demand and growth needs when working with borderline patients. Students should be educated regarding the impulse to make an exception with borderline patients despite how clearly a specific boundary may seem (Guitheil, 1989). If a boundary is crossed, regardless of how well intentioned, it may be misconstrued by the patient or peers and perhaps destroy therapy or escalate further into a legal matter. The results of such actions must be clearly demonstrated in order to sensitize students to the potentially disastrous results. The more informed students are of these issues, the better they will be prepared in their professional lives.

Boundary Violations

Within the context of the therapeutic relationship, the opportunity to cross treatment boundaries can be great. Gratifying the patient's needs by giving the patient a reassuring hug, making a self disclosure, or writing a letter on the

patient's behalf, may indeed affect the therapeutic boundaries of the relationship (Smith & Fitzpatrick, 1995).

Particular dynamics are used by the borderline patient in an attempt to control the therapist. The patient may rage at the therapist in hopes of changing his style or preventing him from setting therapeutic limits. The patient's neediness or dependency may cloud the therapist's therapeutic judgment and indulge his narcissistic fantasy to be everything to the patient. Borderline patients often have boundary difficulties and may attempt to merge with the therapist. The ensuing confusion may distort the therapist's perspective of the treatment and cause a further merger with the patient.

A borderline patient is likely to attempt boundary violations, including those sexual in nature. Patients with borderline personality disorder conspicuously constitute the majority of patients who falsely accuse their therapists of sexual involvement. Unfortunately, false accusations represent only a minuscule fraction of the total allegations; the accusations are usually true. Therapists must become aware of repeating a pattern of errors within countertransference responses (Gutheil, 1989)

When maintaining proper treatment boundaries, therapists are strongly encouraged to seek supervision, consultation or enter their own therapy to avoid boundary violation (Pope, 1987; Strasburger, Jorgenson, & Sutherland, 1992). If the therapist, upon self-reflection, finds himself saying, "I don't normally do this"

he may already be in grave danger. The relationship may have become "special" in some way and the desire to continue in this direction may result in irreparable harm to both patient and therapist. If the reader is interested in further study of sexual misconduct and boundary violations in treatment, he is urged to read the work of Pope, Sonne and Holroyd (1993) for more detailed information.

Should a therapeutic boundary be crossed, there are some steps the therapist can take to protect himself (Gutheil & Gabbard, 1993). The therapist should reason through any action that may be construed as a boundary violation. If the patient has made a questionable request, the nature of the request should be considered and the benefit to the patient must be very clear to the therapist. Due to the nature of the borderline's rage, the therapist can protect himself by documenting all interactions with the patient. When a boundary violation becomes evident to the therapist, it should be examined as part of the therapy process. Processing the meaning of the event with the patient and discussing possible alternatives to prevent a similar boundary violation in the future. As stated earlier, treatment contracts are particularly helpful for working with borderline patients.

Countertransference issues reach further than the therapist's office; they are equally effective in the laboratory as well. Investigators attempting to conduct research with borderline patients must also be cognizant of the borderline's ability to merge and abandon investigative work. Some issues to be aware of are (a) the impulsivity of borderline individuals may reflect a high drop-out rate in research

causing a decrease in sample size, (b) researchers and staff may experience the external difficulties of countertransference through unrealistic dedication to the patients in the research project, (c) attitudes of suspicion or interest toward the patient, and (d) the recurrence of previous neurotic character traits in the investigator including severe compulsiveness or rigidity in the approach taken by the researcher toward the subject (Snyder & Pitts, 1986). The researcher must remain mindful of these possible pitfalls as well as his own narcissism, which may become influenced by the subjects.

As a final note on the discussion of countertransference and its effect on the therapist, the student is urged to familiarize himself with APA Ethical Principles of Psychologists and Code of Conduct (APA, 1992). The code of ethics clearly states a therapist is neither to engage in sexual intimacies with any past or present patients, nor engage in therapy with any former sexual partners.

Termination Issues

Several authors have noted that most clinicians working with borderline patients work toward character change but do not expect a "normal" character to develop (Sansone, Fine, & Baker-Dennis 1991). The most common reasons for termination relate to the cycling of the borderline syndrome. The patient no longer sees the need for treatment and her acting out is a means to end the therapy. Common concerns experienced by the patient during termination process are regression, acting-out, and self-destructive behaviors.

The therapist's prevention of termination with a borderline patient may have many causes including the narcissistic self-indulgence of a dependent patient; the therapist's fulfillment of a fantasy through vicarious living of the patient's life, and the therapist's fundamental financial concerns. The therapist must also reflect on his own personal history of separation and loss and discover if it interferes with the termination process (Brady, Guy, Poelstra, & Brown, 1996). It is essential that the therapist take precautions through self-introspection at the time of termination to determine its true meaning.

Violence Against Therapists

Research on therapist safety has shown that all therapists can be potentially at risk for violence by a patient. Guy, Brown and Poelstra (1990) found that 39 percent of respondents of their study (N = 340) reported that they had been threatened with physical attack by their patients at some time. Subjects for the study were drawn from a computer generated randomized sample of American Psychological Association (APA) members who belonged to Divisions 29 (Psychotherapy) and 42 (Independent Practitioners). Both divisions were represented by equal numbers. Of the initial sample (N = 750), 340 of the individuals completed and returned the two-page anonymous survey which included demographic, theoretical orientation, employment site, number and types of patients seen per week and number and severity of patient attacks, as well as any variables regarding the circumstances of the attack.

Male therapists were more likely to be attacked than female therapists (40.6% vs. 32.6%). A stepwise multiple regression revealed that therapists employed in public psychiatric wards or hospitals received the greatest number of verbal threats ($p < .001$) and were also the most frequently attacked ($p < .001$). A discriminate-function analysis was computed to examine the various relations between the likelihood of being attacked and the variables of therapist's age, sex, years of experience, theoretical orientation and amount of training received in violent patient management. The results did not yield any significance within the comparisons. Nearly 39 percent of therapists have been attacked either verbally, physically or both and no clear profile of a "therapist-victim" is apparent. No connection could be found between the factors of sex, age, theoretical orientation, management of patient violence and attacks on therapists. Additionally, no other relationships were found between number of threats and the therapist's sex, age or theoretical orientation. Clinicians should take into account their work site, amount of training relating to assaultive behavior, and protection of personal information through non-disclosure. It is important for all mental health professionals to be aware of this danger and incorporate basic safety measures into their practice. The implications of such attacks is an interesting issue that warrants further investigation.

Therapist Well-Functioning and Self Care

Well-Functioning is defined as the enduring quality in the therapist's professional functioning over time and in the face of professional and personal stressors (Coster & Scwebel, 1997). Therapists have many factors to contend with in life and practice aside from the dynamics of working with borderline patients. The most common personal problems interfering with therapist well-functioning are emotional exhaustion and fatigue (Mahoney, 1997). A study was conducted to examine the impact of personal distress on patient care (Guy, Poelstra, & Stark, 1989). Of the initial sample (N=749), 318 therapists completed and returned the two-page anonymous questionnaire which included demographic information and a variety of descriptive variables relating to the experience and impact of personal distress. No specific types of therapist distress were found associated with either decreased treatment quality or inadequate care. However, those experiencing job stress ($p < .01$) were most apt to deny providing reduced quality of patient care as a result. The therapists surveyed experienced problems and difficulties from many different aspects of their lives. Furthermore, the unique characteristics of therapists' personal or professional lives seemed to function independently of their experience of personal distress. More specifically, the results did not provide an identifiable "distress-prone therapist" profile (Guy, et al., 1989).

Most therapists do not remain in therapy themselves for long periods of time.

Most distressed individuals, therapists included, do not bring their problems to other therapists, but struggle on their own or with help from friends and family (Mahrer, 1997). Well-functioning therapists employ certain methods in their lives to assist them in handling difficult patients and various life problems. Coster and Schwebel (1997) designed a study to discover the methods therapists use to promote their own well being. The results of their study showed the following self-care items to be important in the well-functioning of therapists: (1) self awareness/self monitoring, (2) personal values, (3) preserving balance between personal and professional lives, (4) relationship with spouse/partner/family, (5) personal therapy, (6) vacations, (7) relationships with friends, (8) professional identity, (9) mentor relationships, and (10) informal peer support. The authors concluded that psychologists maintain a normal state of well-functioning if they are able to manage inevitable stressors of daily as well as professional life. Psychologist impairment was not viewed by the participants of this study as a deficiency in professional skills but as inadequate coping mechanisms to deal with stressors that overwhelm the individual. The results further suggested that well-functioning could be protected by improving coping resources through educational opportunities both during graduate school (Lamb, et al. 1987) and throughout the professional career of the individual (Cherniss, 1995; Deutsch, 1985; Guy, 1987; Kilburg, Nathan, & Thoreson, 1986; Suran & Sheriden, 1985).

Psychotherapy can be a stress producing occupation in which the individual may experience greater vulnerability than in other careers. In accepting the fact that vulnerability and stress can greatly affect the therapist's ability to work therapeutically, it is important to recognize early warning signs of impairment. Coster and Swebel (1997) recommend that a therapist employ methods of self-reflection by questioning changes in patient load, types of patients, or any changes in his personal life such as relationship or financial difficulties. If any changes have been discovered, further self-examination should proceed as if the therapist were addressing a patient and implementing a plan of action. The authors also suggest if introspection and assistance from a trusted peer does not seem to improve the psychologist's state of mind, personal therapy may be an important early intervention into what could become a very litigiously dangerous position for the impaired psychologist.

Conclusions

Some form of countertransference occurs in all therapeutic relationships. The borderline patient, in particular, can elicit powerful feelings in the therapist. The therapist is challenged to understand the countertransference and use it to aid the patient in better self-understanding. The purpose of this paper has been to review the literature on countertransference with BPD patients and discuss its effects on the life of the therapist. In order to complete this discussion, a review on the

etiology of borderline personality disorder was included as well as trends in treatment.

Despite extensive studies on this subject, many researchers fail to agree on a clear definition of borderline personality disorder. Relying solely on the DSM –IV (APA, 1994) criteria to interpret BPD fails to illustrate the depth of this disorder. Viewing BPD from a dimensional perspective rather than a criteria based disorder enables the therapist to implement and modulate the countertransference. Tyrer's (1994) demonstration of the border lines of borderline personality disorder clearly illustrates the richness of understanding BPD from a dimensional perspective. The dimensional perspective provides the therapist with a broader understanding of the fluidity of BPD. In particular, the therapist gains a better understanding the patient's oscillating and splitting behaviors which in turn may allow some predictability of the patient's behavior. Treatment of the patient may be modified to conform to the fluidity of the disorder without damaging the countertransference relationship.

The biopsychosocial model of mental disorders posits that the interactions of biological, psychosocial and environmental risk factors best account for the development of mental disorders (Engel, 1980). There has been a link in the research between BPD and childhood sexual abuse. More specifically, the research has found borderline personality disorder to be more prevalent in females than males. From another perspective, it can be stated that early and chronic

childhood trauma may actually interfere with neurocognitive development. The research of Burgess (1990), using instruments sensitive to information processing, found more frontal lobe impairments among subjects with BPD than among controls. The current research seems to indicate that brain dysfunction may be evident in borderline personality disorder. Future research in this area should incorporate measures of brain dsyfunction, environmental and psychodynamic factors in order to determine in which direction the interactions occur.

The trend in the literature seems to be heading in the direction of conceptualizing countertransference not as an isolated reaction to a patient's behavior but an intra-relational experience that informs the therapist in an intimate way about the experiences of the patient. It is a potentially positive addition to treatment because it allows the therapist to experience the intense, primitive and regressive defenses of the patient (Rosenbush, 1989). An untapped area in the research of countertransference appears to be the measurement of countertransference and the manner in which it is experienced by both the therapist and the patient. Ryle (1996) has developed a measure to compare the therapist's countertransference to the oscillating self-states of the borderline patient. Developing a measurement of countertransference would prove beneficial not only to the patient as Ryle (1996) has demonstrated, but also for the therapist's well-functioning. A measure stating or predicting possible misuse of countertransference could prevent the therapist from potentially harming a patient

as well his practice. The research has begun with some success but much opportunity still remains. The caveat prevails, that countertransference is a double-edged sword and a therapist committed to personal growth will be in a better position to understand his own countertransference and use it successfully to assist the patient.

Historically, borderline personality disorder has been treated in the psychoanalytic tradition with long term and intense psychotherapy. The dropout rates for borderline patients in twice-weekly psychodynamic psychotherapy sessions are as high as 46 to 67 percent after six months (Gunderson, 1984; Gunderson, et al., 1989; Skodol, Buckley & Charles, 1983; Smith, Keonigsberg, Yeomans, Clarkin, & Selzer, 1995).

Crisis intervention and psychopharmacological assistance have both been found to be beneficial forms of treatment. Due to their chronic instability, crisis intervention may be the only treatment some borderline patients receive. Psychopharmacological control of affective disregulation, impulsive aggression, cognitive distortion and anxiety are helpful in ameliorating symptoms which can be disruptive to treatment as well as to quality of life (Soloff, 1994).

Dialectical Behavior Therapy seems to be the most current as well as successful trend in the treatment of BPD. It targets the reduction of suicidal, therapy interfering and quality of life-interfering behaviors, and replaces these dysfunctional behaviors with new skills learned through the skills training

component of the treatment (Shearer & Linehan, 1994). A one-year course of DBT treatment appears to be more helpful in the borderline population than other forms of treatment but does not result in sustained gains over time. Dialectical Behavior Therapy appears to be a consistent factor in shorter hospitalization both during and after one year of treatment.

The therapist's role whether it is in a traditional psychodynamic relationship, or an alternative form of treatment is to assist the patient in acquiring what was missed in the early years of development. The difficulty lies in the fact that the patient has had many years to learn unsuccessful patterns of coping. Research has yet to discover the method of treatment that is successful for each patient. It is plausible that there is not one correct therapy for the borderline patient, but a combination of methods implemented at particular intervals during the treatment process. Perhaps by incorporating the dimensional approach and understanding BPD from a developmental standpoint, borderline patients who do remain in therapy may experience more success.

Research seems to indicate that the inclusion of a therapeutic contract within the treatment plan may ensure a higher compliance rate for treatment. Moreover, results indicated the therapist's contribution both in the development of the contract and in the therapeutic alliance correlated positively with the length of time a borderline patient remained in treatment.

It is essential that psychology students be continually made aware of the ongoing countertransference and dynamic issues of sex and rage in the borderline patient. A borderline patient is more likely than other patients to attempt boundary violations including those sexual in nature. When maintaining proper treatment boundaries, the therapist is strongly encouraged to protect himself by documenting all interactions with the patient. The therapist can further ensure proper treatment boundaries by seeking supervision, consultation or entering his own therapy.

Research on therapist safety has shown that all therapists can be potentially at risk for violence by a patient. Nearly 39 percent of therapists have been attacked either verbally, physically or both and no clear profile of a "therapist-victim" is apparent. However, male therapists were more likely to have been attacked than female therapists. Clinicians should take into account, their work site, amount of training related to assaultive behavior, and protection of personal information through non-disclosure.

The most commonly reported problems interfering with therapist well-functioning are emotional exhaustion and fatigue (Mahoney, 1998). Therapists' personal and professional lives seemed to function independently from their experience of personal distress. Research results do not provide a profile of an identifiable "distress-prone therapist" (Guy, et al., 1989). A study by Coster and Schwebel (1997) postulated that well-functioning therapists include the following

aspects to their daily living: (1) self awareness/self monitoring, (2) personal values, (3) preserving balance between personal and professional lives, (4) relationship with spouse/partner/family, (5) personal therapy, (6) vacations, (7) relationships with friends, (8) professional identity, (9) mentor relationships, and (10) informal peer support. The authors concluded that psychologists maintain a normal state of well-functioning if they are able to manage inevitable stressors of daily as well as professional life. The results further suggested well-functioning could be protected by improving coping resources through educational opportunities both during graduate school (Lamb, et al, 1987; Podrygula, 1994) and throughout the professional career of the individual (Cherniss, 1995; Deutsch, 1985; Guy, 1987; Kilburg, Nathan, & Thoreson, 1986; Suran & Sheriden, 1985).

When working with these challenging patients, the therapist must employ methods to enhance his own well-functioning. Most importantly, the therapist must acknowledge that he can not become all to the patient. Often, the individual's pull to become a therapist is the wish to make investments in others that will enhance the quality of their life. The borderline patient has the same wish for the therapist. However, the well-functioning therapist depends on his ability to recognize his countertransference and maintain therapeutic boundaries in the relationship. Continuing to remain in relationships with colleagues or receiving supervision for difficult cases alters the perspective of the therapist and can contain the negative countertransference. The therapist should continually be

aware of his own issues and seek therapy for himself if the boundary becomes blurred.

Psychotherapy as a profession, has the potential to create more stress for an individual than other occupations. It is also a profession that allows the individual to experience a greater sense of vulnerability both in himself and the patients he treats. In accepting the fact that vulnerability and stress can greatly effect the therapist's ability to work therapeutically, it is important to recognize early warning signs of impairment.

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